**Medicare Supplement**

These standards are provided to assist the insurer in filing forms and rates. They are not intended to be all-inclusive, and are a work in progress. The standards are a brief synopsis and do not contain all requirements or exceptions. All citations should be reviewed. ***Insurers are responsible for assuring that forms and rates submitted comply with Utah Insurance Code and Rules, UCA § 31A-21-201(2). If submitted filings are found to be out of compliance they may be referred to our Market Conduct Division for review and possible action.***

| | | |
|---|---|---|
| **Filing Procedures** | | |
| Filing Submission | 31A-21-201<br>R590-220 | Requirements and processes for submission of forms, rates and related reports. The insurer is responsible for compliance with Utah Code and Rules. A filing that does not comply with code, rules, or standards may be rejected. Rejected filings are not considered filed with the department. |
| Sample Data | R590-220-7 | Each form must be completed with data that is representative of the market intended to accurately reflect its purpose and use. |
| Variability | R590-220-7 | All variable information must be bracketed with an explanation of the variables. Changes must be refilled prior to use. |
| **General Requirements** | | |
| Application | 31A-21-201(3)(a)(i) | Application must conspicuously provide the exact name of the insurer, and the state of domicile of the insurer. Questions used to elicit health condition information may not be vague and must reference a reasonable time frame in relation to the health condition. An application that includes the question of rated, modified, or issued other than as applied for must reference "to your knowledge." |
| Arbitration | R590-122 | Compulsory non-binding arbitration is not permissible. An arbitration provision must be properly disclosed in the policy, certificate, application and enrollment forms. It may not deprive Utah courts of jurisdiction over an action against an insurer, except as provided in permissible arbitration provisions. |
| Certificate | 31A-21-311 | Group certificates shall contain a summary of the essential features of the insurance coverage, including any rights of conversion. The certificate must conspicuously provide the exact name of the insurer, and the state of domicile of the insurer. |
| Claim Settlement | 31A-26-301.6<br>R590-146-13<br>R590-192 | Provides for fair and rapid settlement of claims and protection of claimants from unfair claims settlement practices. Interest must be paid when claim is not paid timely. |
| Company Name | 31A-21-201, 301 & 311 | The exact name of the insurer and its state of domicile must appear conspicuously in the policy. |
| Coordination of Benefits | R590-131 | All policies shall comply with the Medicare payor rules. |
| Definitions | 31A-1-301<br>R590-146-3 | Forms must comply with these definitions. |
| Discretionary Clauses | R590-218 | Discretionary clauses in forms that are not associated with ERISA employee benefit plans are prohibited. The rule provides required language that must be included in ERISA employee benefit plans sponsored by employers if the insurer is the claim or plan administrator. |
| Endorsement or Rider | 31A-21-106(2)<br>R590-146-17(2) | A contract may not be modified unless it is in writing and requires a signed acceptance by the insured. If additional premiums are charged for endorsement benefits, the premium shall be disclosed on the policy or certificate. All riders or endorsements added to a Medicare Supplement policy after date of issue or at reinstatement or renewal shall require a signed acceptance by the insured. |
| Examination Period | 31A-22-620(6)<br>R590-146-17(A)(5) | Required time period an insured has for policy examination. The applicant has the right to return the policy or certificate within 30 days of its delivery and to have the premium refunded. |
| Felony, riot or insurrection | 31A-21-201 | May exclude losses resulting from an insured's *voluntary* participation in a felony, riot or insurrection, or similar act. |
| Grace Period | 31A-22-607 | Policies shall provide a grace period. Group policies must provide a 30 day grace period during which the policy must continue in force. |
| Illegal Activities | 31A-21-201 | Exclusions are limited to losses related directly to an insured's voluntary participation. |
| Incontestability | 31A-22-609 | Only a fraudulent misstatement regarding insurability is a basis for avoidance after coverage has been in effect for two years. |
| Incorporation by Reference | 31A-21-106 | Except for federal and state law, regulations or public directive, forms may not contain any agreement or incorporate any provision not fully set forth in the policy, application, or attached documents. |
| Jurisdiction | 31A-21-314 | Policy cannot contain any provision requiring it to be construed according to the laws of another jurisdiction, or deny Utah courts jurisdiction. |
| Limitation of Actions | 31A-21-313 & 314 | Rights of action against an insurer. Actions must commence within three years after inception of the loss. |

| | | |
|---|---|---|
| Nondiscrimination Among Health Care Professionals | 31A-22-618 | No insurer may unfairly discriminate against any licensed class of health care providers by structuring contract exclusions that exclude payment of benefits for the treatment of any illness, injury, or condition by any licensed class of health care providers when the treatment is within the scope of the licensee's practice. |
| Outline of Coverage | R590-146-17(D) | Requirement for Outline of Coverage. |
| Premium | R590-146-17 | Required notice of premium change. |
| Proof of Loss and Notice | 31A-21-312<br>R590-192<br>Bulletin 87-6 | Proof of loss provision must allow notice and /or proof of loss to be filed as soon as reasonably possible. Proof of loss provisions may not contain a limitation that it applies only when the insured is legally incapacitated. |
| Return of Premium | 31A-21-302 | All excess premium payments must be returned upon such finding. |
| **Specific Requirements** | | |
| Advertising | 31A-22-620(7)<br>R590-146-19 | Medicare supplement advertisement must be filed upon the request from the commissioner. |
| Application Forms and Replacement Notice | R590-146-18 | Requirements for application forms and replacement coverage. |
| Benefit Standards | R590-146-8 | Standards for all Medicare Supplement policies or certificates delivered or issued for delivery in this state. |
| Definitions | R590-146 | Definitions in the forms may not exceed the definitions in these rules. A definition in Rule R590-146 will supercede a definition that also appears in Rule R590-126. |
| Disclosure | R590-146-17 | Required disclosures. |
| Duplicative Benefits | R590-146-6.C. | No Medicare supplement policy or certificate shall contain benefits that duplicate benefits provided by Medicare. |
| Exclusionary Riders | R590-146-6.B. | No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions. |
| Policy Exclusions | R590-146-6.A, B, & C | Except for permitted preexisting condition clauses, no policy or certificate may be advertised, solicited or issued for delivery in this state as a Medicare supplement policy if the policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare. |
| Preexisting condition | R590-146-8.A.1 | A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six months from the effective date of coverage for a preexisting condition. A preexisting condition shall not be defined more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six months before the effective date of coverage. |
| Renewability | R590-146-8.A(5) | Each Medicare supplement policy shall be guaranteed renewable. It may not be cancelled or non-renewed for any reason other than nonpayment of premium or material misrepresentation. If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Subsection 8A(5)(e), the issuer shall offer certificate holders an individual Medicare supplement policy. |
| Replacement Provisions | R590-146-23<br>R590-146-8(5)(c) | If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate to the extent such time was spent under the original policy. |
| Spouse Termination | R590-146-8.A.4 & 5 | No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium. |
| Standardized Plans | R590-146-9 | Each issuer must make available a policy or certificate that includes the basic "core" package of benefits to each prospective insured. An issuer may make available any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic core package, but not in lieu of it. Benefit plans shall be uniform in structure; language, designation and format to the standard benefit plans "A" through “L.” |
| **Medicare Select Requirements** | | |
| Medicare Select Requirements | R590-146-10 | No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this section. Medicare Select Plans are required to comply with all sections of R590-146, not just section 10. |
| Plan of Operation | R590-146-10.D, E & F | A Medicare Select policy may not be issued until the issuers Plan of Operation is filed and approved by the Commissioner. The filing must contain at least the information required in R590-146-10.E. Any proposed change, except for network providers, must also be filed. |

| | | |
|---|---|---|
| Opportunity for Other Medicare Products | R590-146-10.N | Issuers shall make available the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision, if available. The issuer shall make the policies and certificates available without requiring evidence of insurability. |
| **Rating Requirements** | | |
| Filing Requirements | R590-146-14.A<br>R590-146-15.C<br>R590-85 | All required information must be submitted. The insurer may not revise their rates until they receive the filing has been "Filed for Acceptance" by the department. The effective date of the revision must be at a date later than the date indicated on the stamp. Rate revisions must be implemented within 12 months of the filed date. |
| Guaranteed Issue Rate | Federal Transmittal 01-01 | Insurers must offer persons applying during a guaranteed issue period the lowest available rate.<br>Refer to http://www.cms.hhs.gov/Medigap/Downloads/mdgp0101.pdf. |
| Premium Rates | 31A-22-602 & 620(4) | Premiums must be reasonable relative to benefits. |
| **Reporting Requirements** | | |
| Grievances | R590-146-10.K(6) | Due March 31 each year. Issuers shall file the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances. |
| Annual Filing of Premium Rates | R590-146-14.C.<br>R590-220-11 | Due May 31 each year. The filing MAY NOT contain a request for an increase. Refer to the NAIC Medicare supplement manual for a checklist on all required information. |
| Benchmark / Refund Calculation Report | R590-146-14.B. | Due May 31 each year. Forms are available on our website. |
| Multiple Policy Report | R590-146-22 | Due May 31 each year. All insurers must submit even though the response is "NONE." Forms are available on our website. |